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May 17, 2007

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Mr. Dennis G. Smith, Director
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Centers for Medicare and Medicaid Services
Department of Health and Human Services
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Dear Mr. Smith:

Thank you for appearing before the Domestic Policy Subcommittee at its May 2, 2007. As you know, we convened the hearing after the inexcusable death of 12-year-old Medicaid-eligible child, Deamonte Driver, from a brain infection resulting from untreated tooth decay. One of the purposes of the hearing was to determine how federal and state management of the Medicaid program allowed this tragedy to occur. We also hope to learn what steps should be taken to prevent future unnecessary suffering or death due to untreated tooth decay among the 30 million low-income children that Medicaid covers.¹

Although states administer the Medicaid program on a day-to-day basis, the federal government funds more than half the cost of the program. Under the federal law, the Secretary of Health and Human Services (HHS) is responsible for ensuring that federal Medicaid funds are effectively spent by monitoring and enforcing compliance with federal Medicaid requirements by states that elect to accept federal Medicaid funds.² In this case, at least two such requirements are at issue:

- States must provide all Medicaid-eligible children coverage for preventive dental care and necessary treatment services and report annually on their performance;³ and
- States must pay dentists and other providers at rates that are sufficient to ensure that covered services are available to Medicaid beneficiaries to at least the same extent as they are to the general population.⁴

¹ Congressional Budget Office, *Fact Sheet for CBO's March 2007 Baseline: Medicaid*, March 6, 2007.

² Section 1904 of the Social Security Act, 42 U.S.C. 1396c.

³ Section 1902(a)(43) of the Social Security Act, 42 U.S.C. 1396a(a)(43).

We invited you to testify because you are the HHS official responsible for overseeing state compliance with federal Medicaid requirements, including those relating to coverage of children's dental care and payment of dental providers. As you point out in your written testimony, in 2005 two-thirds of Medicaid-eligible children did not receive any of the dental services—whether preventive or for treatment—to which they are entitled.⁵ Given this almost complete violation of federal Medicaid requirements, you were asked at the hearing what steps you have taken to bring states into compliance with federal law.

In your opening statement, you testified that “[S]anction and enforcement at the federal level fundamentally means taking away money from states... that is something we do not take lightly.” For the record, we do not take noncompliance with the federal law lightly—especially when it contributes to the avoidable death of a 12-year-old child.

In follow-up questioning, you underscored your view that your enforcement options are limited: “The enforcement tools, as I mentioned earlier, are to sanction the state financially.” You also acknowledged that “I have not sanctioned states for the access issue in dental care.” The implication of your statements is that you are effectively powerless to enforce federal law because fiscal sanctions are too onerous and you have no other enforcement tools at your disposal. This implication is both misleading and inaccurate.

You have under current law a number of options for enforcing compliance with federal Medicaid requirements relating to children's dental care. You can—

- Conduct a critical incident review of Deamonte Driver's death in order to determine why he was unable to access the dental care that he needed and to which he was entitled while a Medicaid beneficiary. Identify the steps that state Medicaid programs can take to avoid another such incident and share this information with all state Medicaid programs.
- Make children's access to dental care a CMS enforcement priority, and clearly communicate this priority to all states. In March of this year you wrote to state Medicaid directors about encouraging them to consider covering recommended tobacco-dependence treatment services. You could do the same with access to children's dental services. Like smoking cessation, the provision of dental care to children addresses “an important public health issue,” is “geared toward reducing adverse health effects in the Medicaid population,” and is consistent with “the Department's goal of seeking wellness and prevention as rigorously as treatment.”⁶

⁴ Section 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. 1396a(a)(30)(A).

⁵ Testimony of Dennis G. Smith, Director, Center for Medicaid & State Operations, before the Subcommittee on Domestic Policy, Committee on Oversight and Government Reform, May 2, 2007, p. 5.

⁶ SMDL #07-004, March 22, 2007, <http://www.cms.hhs.gov/SMDL/downloads/SMD032207A.pdf>

- Establish a standard that state Medicaid programs are expected to meet for the provision of dental services to children. CMS already has in place a goal that 80 percent of Medicaid children receive the health screenings to which they are entitled. Your agency has not, however, set a goal for states regarding the percentage of eligible children who receive preventive dental services and the percentage who receive dental treatment services.⁷ Such performance standards, if based on sound public health considerations, would help you communicate to state Medicaid programs federal policy priorities and performance expectations.
- Improve current reporting requirements for states so that you can better determine whether they are in compliance with federal law and whether Medicaid children are receiving the dental services to which they are entitled. In its testimony before the Committee, the Government Accountability Office (GAO) stated that the CMS 416 reporting form, your agency's "primary tool for overseeing the provision of dental services" to children enrolled in Medicaid, is "not sufficient for overseeing the provision of dental and other required EPSDT services in state Medicaid programs."⁸ The GAO has identified the specific limitations of the current report that must be addressed if the reports are to be used to assess state progress in providing required dental services to Medicaid-eligible children.⁹
- Ask questions of those states that report on their CMS-416 forms that less than 50 percent of their Medicaid-eligible children made a dental visit of any kind in the previous year. Try to determine why the state's child dental use rates are low. Are the payment rates for dental services sufficient? If the state contracts with managed care organizations for the provision of dental care to children, are the MCOs delivering the services for which they are responsible? What steps is the state taking to improve access to dental care?
- Post the CMS 416 reports on the CMS website as they are received. Use the information from the individual state reports to rank the states in order of performance vis-à-vis the provision of preventive and restorative dental care to Medicaid-eligible children, and post the ranking on the CMS website. Transparency of this compliance data would enable state policymakers, beneficiaries, and taxpayers to learn how effective their state Medicaid program is in relation to programs in other states in achieving the public health objective of increasing access to needed dental care by low-income children.
- Ensure that state Medicaid programs have ready access to the policy guidance they need in order to cover children's dental services in compliance with federal law. You could revise the *Guide to Children's Dental Care in Medicaid* that you issued in October 2004 so as to incorporate the recommendations for Medicaid

⁷ Statement of James Cosgrove, Acting Director, Health Care, *Medicaid: Concerns Remain about Sufficient of Data for Oversight of Children's Dental Services*, GAO-07-826T, May 2, 2007, p. 8.

⁸ *Id.*, pp. 3, 7.

⁹ *Id.*, pp. 13-14.

reimbursement policies for dental services and for state oversight of managed care organizations that were deleted from that version.¹⁰ In addition, you could update the State Medicaid Manual¹¹ to specify what levels of reimbursement are sufficient to ensure access to services of dental practitioners in both a fee-for-service and managed care context.

- Issue a letter to State Medicaid Directors reminding states of their obligations under federal law to make dental services available to Medicaid-eligible children and asking them to submit “plans of action” for ensuring, within three years, that Medicaid eligible children have adequate access to dental services. CMS issued such a letter in January 2001 that included a 4-page appendix describing considerations in establishing market-based dental fees.¹²
- Exercise your authority under current law to assess civil money penalties against any managed care organization (MCO) that has contracted with a state Medicaid agency to provide dental services and has substantially failed to do so, or that misrepresents or falsifies information to the state Medicaid agency regarding its performance under the contract.¹³ While state Medicaid agencies should exercise their own contractual remedies in the event of noncompliance by an MCO, use of the Secretary’s civil money penalty authority in cases where MCO enrollees are not receiving children’s dental care would send an important signal to both states and MCOs that CMS views the provision of such services as an enforcement priority.
- Use your authority to withhold federal matching funds from a state Medicaid program if it actually fails to comply the requirements of federal law until you are satisfied that the program is back in compliance with federal law.¹⁴ As you know, the amounts withheld need not affect a state’s entire Medicaid program but may instead be targeted to the specific noncompliance. For example, you could deny matching funds for the costs of the state Medicaid director’s salary until his or her program is in compliance; this would indicate disapproval of the program’s performance without limiting access to matching funds for the costs of providing covered dental services that would result from improved performance.¹⁵ It should also be emphasized that the CMS compliance process gives states several opportunities to correct their performance before funds are actually withheld,

¹⁰ Majority Staff Memorandum to Representative Elijah E. Cummings, “Analysis of Alterations to the *Guide to Children’s Dental Care in Medicaid*,” May 2, 2007, <http://domesticpolicy.oversight.house.gov/documents/20070502162315.pdf>

¹¹ <http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927&intNumPerPage=10>

¹² SMDL #01-101, January 18, 2001, <http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS056653&intNumPerPage=10>

¹³ Section 1903(m)(5) of the Social Security Act, 42 U.S.C. 1396b(m)(5).

¹⁴ 42 C.F.R. 430.35(c).

¹⁵ 42 C.F.R. 430.45(a).

including an opportunity for an administrative hearing and reconsideration by the Department,¹⁶ as well as the right to judicial review.¹⁷

Finally, we would note the findings of a recent GAO report on Medicaid Financing. That report reviews your oversight initiative, begun in August 2003, under which “a state’s submission of a proposal to change provider payments in its State Medicaid plan... triggers CMS scrutiny of the appropriateness of any related financing arrangement.” GAO finds that under your initiative, “CMS withholds approval of a proposed state plan amendment until obtaining satisfactory assurances that a state is ending financing arrangements the agency finds to be inappropriate.”¹⁸

This practice in regard to Medicaid financing policy is not without controversy. GAO raises concerns about the non-transparent nature of your initiative,¹⁹ and others have questioned the appropriateness of holding one state proposal hostage until the state agrees to an arguably unrelated policy change. It is indisputable, however, that you have used this technique to change Medicaid financing arrangements in 29 states—without “taking away money from the states” and without having to “sanction the states financially.”

Clearly you have other enforcement tools at your disposal than the single one you referred to in your testimony before the Subcommittee. We would like to know what steps you intend to take to carry out your responsibility to enforce compliance with federal law in order to ensure that Medicaid-eligible children receive the dental services to which they are entitled, and when you plan to take those steps. Specifically:

1. Will you conduct critical incident review of Deamonte Driver’s death in order to determine what went wrong and to identify the steps that state Medicaid programs can take to avoid another such incident? Will you share the results of this review with all state Medicaid programs? If so, when?
2. Will you make children’s access to dental care a CMS enforcement priority, and clearly communicate this priority to all states? If so, when?
3. Will you establish a performance goal or standard that state Medicaid programs are expected to meet for the provision of dental services to children enrolled in the program? If so, when will you publish such a standard?
4. Will you improve current CMS 416 report so that you can better determine whether states are in compliance with federal law and whether Medicaid children are receiving the dental services to which they are entitled? If so, when will an improved form be ready for use?

¹⁶ 42 C.F.R. 430.45(b)

¹⁷ 42 C.F.R. 430.38.

¹⁸ GAO, *Medicaid Financing: Federal Oversight Initiative is Consistent with Medicaid Payment Principles but Needs Greater Transparency*, GAO-07-214, March 2007, p. 2.

¹⁹ *Id.*, pp. 32-34.

5. Will you ask questions of those states that report on their CMS-416 forms that less than 50 percent of their Medicaid-eligible children made a dental visit of any kind in the previous year in order to determine why the state's performance is inadequate? If so, when will you begin this process?
6. Will you post the CMS 416 reports on the CMS website as they are received and use the information from the individual state reports to post a ranking of the states in order of performance? If so, when?
7. Will you ensure that state Medicaid programs have ready access to the policy guidance they need in order to cover children's dental services in compliance with federal law by revising the *Guide to Children's Dental Care in Medicaid* to incorporate information relating to provider reimbursement and managed care oversight that was edited out of the October 2004 version? If so when will you publish the revised *Guide*?
8. Will you issue a letter to State Medicaid Directors reminding states of their obligations under federal law to make dental services available to Medicaid-eligible children and asking them to submit "plans of action" for ensuring, within three years, that Medicaid eligible children have adequate access to dental services? If so, when will you issue the letter?
9. Will you exercise your authority under current law to assess civil money penalties against any managed care organization (MCO) that has contracted with a state Medicaid agency to provide dental services and has substantially failed to do so, or that misrepresents or falsifies information to the state Medicaid agency regarding its performance under the contract?

Please submit your responses no later than Friday, June 1, 2007.

The Committee on Oversight and Government Reform is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X. An attachment to this letter provides additional information on how to respond to the Subcommittee's request.

If you have any question regarding this request, please contact Noura Erakat of the Subcommittee staff at (202) 225-6427.

Mr. Dennis G. Smith
May 17, 2007
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Sincerely,



Dennis Kucinich
Chairman
Domestic Policy Subcommittee



Elijah E. Cummings
Member of Congress

cc: Darrel Issa,
Ranking Minority